TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Ikechukwu J. Obih, M.D.

Respondent Name
City of San Antonio

MFDR Tracking Number
M4-17-0972-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 7, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DR REFERRED TESTING NO PAYMENT RECEIVED"

Amount in Dispute: $835.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation and review of the claim file it has been determined that no payment is required for this service. Although the position statement indicates the bill is in regards to testing requested by the Designated Doctor we find no evidence in the record that this was requested for the purpose of the exam. This was an alternate rating requested by the treating doctor and are not afforded the same privileges of a Designated Doctor exam. Therefore no payment is being made at this time."

Response Submitted by: Injury Management Organization, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 15, 2016	Evaluation and Management; Needle Electromyography; Nerve Conduction; Electrodes	$835.61	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §127.10 sets out the procedures for a designated doctor examination.
3. Texas Labor Code §408.021 establishes entitlement to medical benefits.
4. Texas Government Code §311.016 defines the code construction process.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 216 – Based on the findings of a review organization
   - Notes: "Denied Per Retrospective Peer Review Determination."
   - This procedure on this date was previously reviewed
   - 18 – Exact duplicate claim/service.
   - 184 – The prescribing/ordering provider is not eligible to prescribe/order the service billed.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the insurance carrier's denial of payment for the disputed services supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason codes 184 – "The prescribing/ordering provider is not eligible to prescribe/order the service billed." Texas Labor Code §408.021(c) requires that "Except in an emergency, all health care must be approved or recommended by the employee's treating doctor."

According to Texas Government Code 311.016(3) states that, unless a different construction is expressly provided, the term "'must' creates or recognizes a condition precedent." For this reason, the requestor must support that treatment was approved or recommended by the employee's treating doctor in order to be entitled to medical benefits.

Review of the submitted information does not support that the disputed service was provided, referred, or approved by the employee's treating doctor. No documentation was found that the disputed services were ordered by a designated doctor in accordance with 28 Texas Administrative Code §127.10(c), as asserted by the requestor. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Even though all the evidence was not discussed, it was considered. For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	February 3, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.